STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235666	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe Court Grand Blanc, MI 48439

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00145466. Based on interview and record review, the facility failed to provide adequate and appropriate interventions, evaluate and revise interventions to prevent the development and healing of pressure wounds for one resident (Resident #1) of three residents reviewed for pressure wounds, resulting in Resident #1 developing a pressure wound to the right and left heel area and the right and left buttock, worsening of the wounds and the potential for pain, infection and deterioration in health and wellbeing. Findings include: Resident #1: A review of Resident #1's medical record revealed an admission into the facility on [DATE] and discharge to acute care hospital on 5/7/24 with diagnoses that included traumatic hemorrhage of cerebrum, chronic kidney disease Stage 2 (mild), heart disease, difficulty in walking, weakness, contusion of scalp, and multiple fractures of ribs, left side, pedestrian on foot injured in collision with motor vehicle. A review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition. A review of the MDS Functional Abilities and Goals revealed admission performance of supervision or touching assistance for eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with toileting hygiene, and upper body dressing and was dependent with bathing, and lower body dressing. A review of the MDS for mobility revealed partial/moderate assistance with roll left and right, sit to stand, chair/bed to chair transfer, toilet transfer and car transfer and substantial/maximal assistance with sit to lying and lying to sitting on side of bed. A review of the MDS revealed the resident was at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries upon admission into the facility. A review of Resident #1's medical record of Skin and Wound Evaluation revealed the following: Wound to Right heel: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 4/5/24. Pressure type, Stage: deep tissue injury: Persistent non-blanchable deep red, maroon or purple discoloration, location: Right heel, in=house acquired, exact date: 4/4/24, measurements: area 8.7 cm(centimeters)2(squared), Length 3.6 cm, width 3.7 cm, wound bed: slough, 60% of wound filled. Notes: Wound noted to rt (right) heel, guest noted with poor po intake, and declines out of bed activity for more then 15-30 min (minutes) in one setting. Poor motivation. Guest prefers to lay on back so he can visualize the TV. Education: Instructed guest to lay side lying position when in bed and that the bed can be moved in order to watch TV. Soft boots provided for when guest is on back. Also instructed guest to get out of bed for meals and therapy and encourage to be out of bed for 2 hours intervals. Daughter at bedside. The picture of the wound was observed to be blackened (eschar, not slough) in color with reddened area at edges encompassing large portion of the heel. -Dated 5/7/24, pressure type wound to right heel; wound measurements: Area 6.3 cm2, length 3.1 cm, width 2.5 cm; wound bed: eschar 100% filled. Goal of Care: Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration; Education: Continue with tx (treatment) and pressure soft boots to keep heels elevated from bed or use of pillows to elevate heels from bed. Will continue to encourage nutrition as he has poor po intake. Remeron initiated. Wound to Left heel: -Dated 4/5/24, pressure type wound to left heel; Stage: deep tissue injury; in-house acquired; exact date: 4/4/24; wound measurements: Area 6.1 cm2, length 3.0 cm, width 2.9 cm, depth not applicable; wound bed not identified; Goal of Care: Healable; Notes: Wound noted to left heel, light purple discoloration. No s/s (signs and symptoms) of infection. -Dated 5/7/24, pressure type wound to left heel; wound measurements: Area 7.9 cm2, length 3.1 cm, width 3. 0 cm, depth 0.1 cm; wound bed not identified; other: pink or red; Notes: Blister now open and pink wound bed remains, small area of purple discoloration noted within wound bed. Tx changed to betadine and cover. Education: Continue with use of soft boots or pillows to keep heels elevatged from bed. Tx changed. Continue to encourage nutrition, guest currently has poor po intake. Wound to Right Gluteus: -Dated 4/5/24, pressure type wound to right gluteus; Stage: Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration; in-house acquired; exact date: 4/4/24; wound measurements: area 2.8 cm2, 1.7 cm, width 2.3 cm, depth 0.1 cm; Notes: Gest noted with wound to rt buttock, tx in place. Guest is incontinent of Bowel and has poor motivation to get OOB (out of bed) for more than 15-30 min at a time. Guest prefers to lay on back and has poor po intake; Education: Encourage side lying position when in bed, good po intake including the supplements provided at HS (nighttime), OOB activity and the use of pillows for positioning. Guest verbalized understanding. Daughter at beside. -Dated 5/7/24, pressure type wound to right gluteus; Stage: Unstageable: Obscured full-thickness skin and tissue loss due to: slough and/or eschar; In-house acquired; exact date: 4/4/24; wound measurements: Area 9.3 cm2, length 2.6 cm, width 5.0 cm, Depth 0.1 cm; Goal of Care: Slow to heal: wound healing is slow or stalled but stable, little/no deterioration; Notes: Wound stable however, surrounding tissue deteriorating with SDTI (suspected deep tissue injury). Wound to Left Gluteus (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 4/5/24, pressure type wound to left gluteus; Stage: Deep tissue injury; in-house acquired: exact date: 4/4/24; wound measurements: area 8.0 cm2, length 4.7 cm, width 2.8 cm, depth 0.1 cm; Goal of Care: Slow to heal: wound healing is slow or stalled but stable, little/no deterioration; Note: Wound noted to buttock with purple surrounding tissue. Tx in place. -Dated 5/7/24, pressure type wound to left gluteus; Stage: unstageable: obscured full-thickness skin and tissue loss due to slough and/or eschar; in-house acquired: exact date: 4/4/24; wound measurements: area 17.9 cm2, length 8.2 cm, width 5.0 cm, depth 0.1 cm; wound bed: slough 50%; Goal of Care: Slow to heal: wound healing is slow or stalled but stable, little/no deterioration; Note: Wound stable nut surrounding tissue with SDTI, tx in place. See note for rt buttock; Education: Continue with turning and repositioning, OOB activity, and encouraging po intake. A review of Resident #1's medical record of Braden Scale for Predicting Pressure Sore Risk documents revealed the following: -Dated 3/19/24, Category: Low Risk with a Score: 16. -Dated 3/25/24, Category: Low Risk with a Score: 15. -Dated 4/1/24, Category: Low Risk with a Score: 17. -Dated 4/8/24, Category: Low Risk with a Score: 18. -Dated 4/22/24, Category: Moderate Risk with a Score: 14. On 7/25/24 at 5:20 PM, an interview was conducted with Confidential Person (CP) A regarding Resident #1 care at the facility. The CP explained that Resident #1 had been visiting his wife at the hospital, was struck by a car in the parking lot and was found by a nurse that worked at the hospital. The CP indicated that Resident #1 had a head injury, fractured ribs, and had lost his upper dentures. The CP reported the Resident, upon discharge from the hospital to the nursing home, was to receive therapy and the plan was to return home. The CP indicated that Resident #1 walked unaided, was driving and independent in caring for himself prior to the accident. After being in the hospital, Resident #1 was walking with assistance with a walker and eating before going to the facility. The CP reported Resident #1, became weaker, had a difficult time eating, did not have his top denture to help him eat, and developed pressure ulcers while at the facility. The CP was asked about interventions of repositioning. The CP reported family was there about every day, rarely did they see him positioned on his side or have boots on or legs lifted off the bed. The CP reported staff said he was to be positioned on his side. Family would come in and he was usually on his back without the boots on. The CP stated, The CNAs would put him on his side, he never refused when I was there, but they rarely positioned him and reported they visited there most days, sometimes in the morning about breakfast and stay until after lunch, sometimes during the day or dinner time through the evening and stated, He was usually positioned on his back with nothing lifting his feet. When asked if Resident #1 refused to lay on his side, the CP stated, no never refused care, and reported that if the CNAs did come in to reposition him, which was rare, he would let them and reported, he was too weak to remove the wedges out himself or remove the boots. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CP reported the Resident had requested to go to the hospital and stated, he insisted, or they would not have sent him. The CP reported the Resident had sepsis, he could not breathe enough, did not eat enough nutrition, sepsis was damaging to his system, had started hospice services while at the hospital and then passed away. A review of the MDS dated [DATE] and the MDS dated [DATE], revealed in Section E - Behavior, E0800 Rejection of Care - Presence and Frequency, Did the resident reflect evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion of care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. The entered code 0 indicated Behavior not exhibited. A review of Resident #1's care plan revealed a Focus (Resident #1's name) is at risk for impaired skin integrity/pressure injury R/T (related to): weakness, decreased mobility, bruising to multiple areas of skin d/t MVA (motor vehicle accident), use of foley catheter. Wound to rt and lt buttocks, and bilateral heels, poor motivation, poor po intake, declines OOB activity for more than 15-30 min at one time, prefers to lay on back while in bed, revision on 4/8/24. Further review revealed, Focus: .risk for impaired skin integrity/pressure . poor motivation, poor po intake, declines oob activity for more than 15-30 min at one time, prefers to lay on back while in bed. Draws knees up in bed rubbing heels on mattress and displacing pillows states he is exercising his legs while in bed, revision on 4/23/24. A review of Resident #1's care plan revealed interventions created or revised on 4/8/24, post development of the wounds, included: -Dietary consult . to promote wound healing, created 4/8/24. -Encourage out of bed activity for 2 hours at a time, created 4/8/24. -Encourage side lying position when in bed, created on 4/8/24. -Encourage to float heels while in bed with the use of soft boots or pillows, created and revision on 4/8/24. -Pressure reduction cushion to w/c (wheelchair) or chair-roho, revision on 4/8/24. -Pressure reduction mattress to bed-LTC 105, revision on 4/23/24. -Provide therapy and encourage participation as ordered, encourage (Resident #1) to exercise legs when OOB to prevent friction to heels or perform leg lifts to prevent friction against mattress, revision on 4/23/24. There was a lack of evaluation for effectiveness and revised to address the Resident not following the intended interventions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Skilled Care Notes for Resident #1 of 5. Behaviors that listed Resists Care was not documented with review of notes from 3/19/24 to 5/6/24. A review of Task documentation for behavior charting did not have refusal of care documented for repositioning, did not have refusal of the heel boots not worn, and did not document when the boots were on or not on. Further review of the Skin and Wound Evaluation notes for Resident #1, revealed the following: -Dated 4/5/24, Instructed guest to lay side lying position when in bed and that the bed can be moved in order to watch TV. Soft boots provided for when guest is on back. Also instructed guest to get out of bed for meals and therapy and encourage to be out of bed for 2 hour intervals. Daughter at bedside. -Dated 4/24/24, Guest refuses to get out of bed, refused therapy very poor appetite . On 7/31/24 at 9:32 AM, an interview was conducted with Unit Manager B regarding Resident #1's facility acquired pressure ulcers. The Unit Manager indicated that the Resident had refusal to reposition in bed, she did spot checks on those that were more compromised than others and reported Resident #1 was repositioned and would go back to his back, the heel boots kicked off and stated, He was doing exercises in the bed, and pushed his heels into the mattress. The Unit Manager reported education to the Resident was provided. The Unit Manager reported that the Resident did not want to get up and once up, would want to lay back down within 15 minutes. The Unit Manager reported the wounds developed by a multitude of things, poor labs, rubbing heels on the bed, lack of activity, poor diet, reported the Resident refused the Resource drink, Remeron was initiated to encourage appetite, but had nausea and poor po intake. The Unit Manager indicated that family had brought in items for the Resident, but he continued to have poor intake. The Unit Manager reported the wounds came on suddenly. On 7/31/24 at 4:10 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #1, who developed four facility acquired pressure ulcers. The DON was asked about a conflict in documentation of repositioning. The CNAs had charted in the task for repositioning that it was completed but there was some documentation that the Resident had refused the repositioning and as well as per interview, the Resident was refusing the repositioning, and intervention to mitigate the pressure to the buttock and wearing the boots, an intervention to mitigate pressure applied to the heels. The DON indicated that the CNAs chart that they go to reposition the Resident and mark as a yes and if the Resident refuses, then they are to go to the Nurse who would chart the refusal. The DON indicated that the Nurse was to chart refusal of care. The DON reported that the wounds were unavoidable, they came on suddenly, the Resident was not taking in adequate nutrition, they decided not to go with a tube feeding, had poor hydration, laboratory values were off, had lack of activity and did not adhere to the interventions that were in place. The DON indicated that an unavoidable pressure ulcer assessment was completed on 3/29/24 by the Nurse Practitioner and before the development of the wounds that Resident #1's prognosis was poor. Therapy notes were reviewed of the Resident walking with a walker and assistance, but the DON reported the Resident not wanting to get out of the bed and when he did, it would last for 15 to 20 minutes, and gave resistance with repositioning. It was reviewed with the DON of the lack of care planned interventions evaluated for effectiveness, changed, or added to address the Resident's resistance to the intended interventions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy titled, Skin Management, revised 5/14/24, revealed, .Overview: Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes . 2. The Braden Scale will be competed upon admission/re-admission, weekly for 4 weeks . to determine the risk of pressure injury development . A review of facility policy titled, Standards of Nursing Practice, revised 4/11/23, revealed, We believe the use of the nursing process ensures appropriate care and services for each resident. We believe that the resident has the right to be involved in the development of the plan of care, to be informed of changes to the treatment plan, and to refuse treatment with the knowledge of the impact of refusal. The delivery of nursing care in the facility is based on a thorough evaluation of the resident to identify his or her care needs. Once resident needs are identified, a comprehensive care plan is developed to attain individualized resident goals. The care plan is implemented by the interdisciplinary team and is continually evaluated for effectiveness. The care plan is updated as necessary to meet the resident's needs .